| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150084 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 08/07/2012 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST VINCENT HOSPITAL & HEALTH SERVICES | 2001 W 86TH ST<br>INDIANAPOLIS, IN 46260 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| S0000 | This visit was for the investigation of one State complaint.<br><br>Complaint Number: IN00104676<br>Substantiated: deficiency cited related to the allegation.<br><br>Facility #: 005075<br><br>Survey Dates: 08-07-12<br><br>Surveyor:<br>Billie Jo Fritch, RN, BSN, MBA<br>Public Health Nurse Surveyor<br><br>QA: claughlin 08/27/12 | S0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150084 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 08/07/2012 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST VINCENT HOSPITAL & HEALTH SERVICES | 2001 W 86TH ST<br>INDIANAPOLIS, IN 46260 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| S0912 | 410 IAC 15-1.5-6<br>NURSING SERVICE<br>410 IAC 15-15-6 (a)(2)(B)(i)(ii)<br>(iii)(iv)(v)<br><br>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:<br><br>(2) A nurse executive who is:<br>(B) responsible for the following:<br>(i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital.<br>(ii) Maintaining a current nursing service organization chart.<br>(iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions.<br>(iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements.<br>(v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital. | | | |
| | Based on document review and interview, the chief nursing executive failed to ensure nursing staff followed physician orders as written for 1 of 5 (P#1) patients on 24 of 34 days. | S0912 | Unit Manager, Unit Educator, Unit Director, and the Quality Consultant met on September 6, 2012 and outlined the following steps in response to this citation:1. Unit leadership will | 10/31/2012 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150084 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 08/07/2012 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST VINCENT HOSPITAL & HEALTH SERVICES | 2001 W 86TH ST<br>INDIANAPOLIS, IN 46260 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Findings included:<br><br>1. Review of medical records on 8-7-12 indicated P#1 had an order written on 2-9-12 1545 hours for sitz baths "at least BID".<br>2. Review of the medical record for P#1 on 8-7-12 lacked documentation of sitz baths BID:<br>2-10-12, none<br>2-11-12, none<br>2-12-12, none<br>2-13-12, none<br>2-14-12, none<br>2-15-12, none<br>2-16-12, none<br>2-18-12, none<br>2-19-12, sitz bath done at 1000 hours<br>2-20-12, none<br>2-23-12, none<br>2-24-12, none<br>2-27-12, sitz bath done at 2200 hours<br>3-1-12, sitz bath done at 2000 hours<br>3-2-12, none<br>3-3-12, none<br>3-5-12, sitz bath at 2206 hours<br>3-6-12, sitz bath at 0400 hours<br>3-8-12, none<br>3-9-12, none<br>3-10-12, none<br>3-12-12, sitz bath at 0800 hours<br>3-13-12, none<br>3-14-12, none on day of discharge | | address each episode of non compliance with the involved registered nurses individually and this discussion will be documented in their file.2. Mandatory registered nurses and technicians education on sitz bath procedure will be completed in October 2012. Ongoing education will occur to registered nurses and technicians to prevent the deficiency from recurring in the future. 3. A pediatric specific procedure on the performance of sitz bath will be written and added to the hospital system prior to October 31, 2012. This written procedure will help prevent the deficiency from recurring int he future. 4. Auditing of documentation of compliance with ordered sitz baths in the pediatric patients will start on October 1, 2012 and end on February 1, 2013. We will audit 100% of pediatric patients with ordered sitz baths during that time period.The Pediatrics Manager will be the responsible party to ensure that all of the items on this plan will be completed. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150084 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 08/07/2012 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER ST VINCENT HOSPITAL & HEALTH SERVICES | | STREET ADDRESS, CITY, STATE, ZIP CODE 2001 W 86TH ST INDIANAPOLIS, IN 46260 | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 3. Interview with B#1 on 8-7-12 at 1535 hours confirmed the physician's order in the medical record of P#1, written 2-9-12 at 1545 hours, is for sitz bath "at least BID"; B#1 confirmed the medical record documentation lacks evidence that the patient or family refused any of the ordered sitz baths; B#1 confirmed the physician's order was not followed as written. | | | |